IN THE CIRCUIT COURT OF
THE 11TH JUDICIAL CIRCUIT
IN AND FOR DADE COUNTY, FLORIDA

GENERAL JURISDICTION DIVISION

CASE NO. 94-08273 CA (22)

HOWARD A. ENGLE, M.D.,
et al.,

Plaintiffs,

vs.

R.J. REYNOLDS TOBACCO
COMPANY, et al.,

Defendants.
_____/

Miami-Dade County Courthouse
Miami, Florida
Tuesday, 9:35 a.m.
March 23, 1999

TRIAL - VOLUME 261

The above-styled cause came on for trial before the Honorable Robert Paul Kaye, Circuit Judge, pursuant to notice.

TAYLOR, JONOVIC, WHITE & GENDRON

APPEARANCES:

STANLEY M. ROSENBLATT, ESQ.
SUSAN ROSENBLATT, ESQ.
CLIFFORD DOUGLAS, ESQ.
On behalf of Plaintiffs

DECHERT PRICE & RHOADS
ROBERT C. HEIM, ESQ.
SEAN P. WAJERT, ESQ.
On behalf of Defendant Philip Morris

COLL DAVIDSON CARTER SMITH SALTER & BARKETT
NORMAN A. COLL, ESQ.
On behalf of Defendant Philip Morris

ZACK KOSNITZKY
STEPHEN N. ZACK, ESQ.
On behalf of Defendant Philip Morris

CARLTON FIELDS WARD EMMANUEL SMITH & CUTLER
R. BENJAMINE REID, ESQ.
DOUGLAS CHUMBLEY, ESQ.
On behalf of Defendant R.J. Reynolds

JONES, DAY, REAVIS & POGUE
RICHARD M. KIRBY, ESQ.
DIANE PULLEY, ESQ.
On behalf of Defendant R.J. Reynolds

KING & SPALDING
MICHAEL RUSS, ESQ.
RICHARD A. SCHNEIDER, ESQ.
On behalf of Defendant Brown & Williamson

CLARKE SILVERGLATE WILLIAMS & MONTGOMERY
KELLY ANNE LUTHER, ESQ.
On behalf of Defendants Liggett Group
and Brooke Group

SHOOK HARDY & BACON
EDWARD A. MOSS, ESQ.
WILLIAM P. GERAGHTY, ESQ.
On behalf of Defendant Brown & Williamson
JAMES T. NEWSOM, ESQ.
On behalf of Defendant Lorillard

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APPEARANCES (Continued)

DEBEVOISE & PLIMPTON
ANNE COHEN, ESQ.
JOSEPH R. MOODHE, ESQ.
On behalf of Defendant The Council for Tobacco Research

GREENBERG TRAURIG HOFFMAN LIPOFF ROSEN & QUENTEL
DAVID L. ROSS, ESQ.
On behalf of Defendant Lorillard

MARTINEZ & GUTIERREZ
JOSE MARTINEZ, ESQ.
On behalf of Defendant Dosal Tobacco Corp.
and Tobacco Institute

KASOWITZ BENSON TORRES & FRIEDMAN
AARON MARKS, ESQ.
NANCY STRAUB, ESQ.
On behalf of Defendants Liggett Group
and Brooke Group

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I N D E X

E X H I B I T S

PLAINTIFFS' EXHIBITS	OFFERED PAGE	ADMITTED PAGE	FOR ID PAGE
None			

E X H I B I T S

DEFENDANTS' EXHIBITS	OFFERED PAGE	ADMITTED PAGE	FOR ID PAGE
None			

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(Whereupon, the following pr dings were had:)

THE COURT: Good mornir , all. Have a seat.

Juror No. 7 has a doctors's apointment today at 5:00, she'd like to get out of here at 4:30.

MS. LUTHER: Judge, these are just some envelopes stamped for the order on the directed verdict motion. I had to leave my office too early yesterday. My secretary didn't have them done yet.

THE COURT: But I didn't rule in your favor yet, right?

MS. LUTHER: That's true, but you have to do an order one way or the other.

MR. ROSENBLATT: Have to?

MS. LUTHER: Hope springs eternal.

THE COURT: Okay, I'll keep these.

So 4:30, it's a heck of a time to tell us.

MR. ROSS: That shouldn't be a problem, Judge. The direct of today's witness will clearly be done this morning. I don't know how long cross will be.

THE COURT: Okay.

MR. ROSENBLATT: Are you including my sidebars?

MR. ROSS: I thought we had a deal about those.

MR. ROSENBLATT: It's a one-way deal. I said to myself yesterday, Judge, after the morning session, after, I don't think I objected, I said, that never happened on their case. Susan says, you let them play a symphony.

THE COURT: I noticed in the paper about Brooke, Limited.

MR. REID: It was in the business section this morning.

MS. LUTHER: I don't know what you're talking about, Judge. I didn't see the paper this morning.

THE COURT: You don't know, they're selling out to PM?

MR. REID: That was in the paper before.

THE COURT: 145 million.

MR. HEIM: Actually, what they did is they sold three of the brands to Philip Morris.

THE COURT: Paid first five million before and now 145, there's going to be 145 over six years. Does that effect us in any way?

MS. LUTHER: No.

THE COURT: Okay. Just wondered. But I don't know if the jury read it or if they read the business section, but I'll ask them again. There always seems to be something in the paper.

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MR. REID: It was buried in the back of the business section.

THE COURT: Yes, but I found it. Not that I have any business reading the business section, but whatever.

Okay. Let's bring the jury in.

THE COURT: I understand that there's going to be a response to Brooke's motion.

MR. ROSENBLATT: Yes, Your Honor.

THE COURT: Is that today? Or don't you know?

MR. ROSENBLATT: I don't think it's ready yet.

MS. LUTHER: Of course, Your Honor, it's my understanding that you wouldn't be waiting for the response before entering a motion.

THE COURT: She says she's going to respond.

MS. LUTHER: Well, she promised she would respond in Broin and she never did.

THE COURT: Well, Broin ended up in settlement. Hope springs eternal.

(The jurors entered the courtroom.)

THE COURT: Well, good morning. How is everybody?

THE JURY PANEL: Fine.

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THE COURT: Over the night has anybody read, seen, been exposed to, watched, talked about or in any way been in contact with any information that regards tobacco, tobacco industry, tobacco products, issues, anything that deals with this case in the related form of tobacco?

And if you did, would it bother you or affect your decision?

No?

Okay. Now we have to proceed with another witness this morning. Is the witness present?

MR. ROSS: Yes. Call Dr. Hugh Gilmore.

THE COURT: Dr. Gilmore.

Thereupon:

HUGH GILMORE, M.D.

having been called as a witness, was duly sworn, examined, and testified as follows:

DIRECT EXAMINATION

BY MR. ROSS:

Q. Good morning, ladies and gentlemen.

Would you please state your name.

A. I'm Hugh Gilmore.

Q. And Dr. Gilmore, what is your address?

A. I'm at 1321 N.E. 14th Street in Miami, I have a practice of medicine in that office.

Q. And you are a medical doctor?
A. Yes, I am.
Q. And what type of practice do you have at that office?
A. I practice internal medicine and cardiology.
Q. Dr. Gilmore, how old are you?
A. 73.
Q. Do you still carry a full patient load in your practice?
A. Yes, I do. I'm in a group of four and we all take an equal load in the practice.
Q. Dr. Gilmore, what is your medical specialty?
A. Internal medicine, cardiovascular diseases, which would be the treatment of the heart and blood vessels.
Q. Tell the jury what does the term "cardiology" means.
A. It refers to the study of heart disease.
Q. I'd like to have you tell the jury a little bit about your background and your education. First tell us, where did you attend college and what degree did you receive?
A. I went to college in Sworthmore, Pennsylvania, a small college outside of Philadelphia, and I achieved a degree as a Bachelor of Arts in

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biology.

Q. Then where did you go to medical school?

A. I went to medical school in Philadelphia at the University of Pennsylvania. I graduated in 1950 with a degree in medicine.

Q. While in medical school did you receive any academic honors?

A. Yes, I was in the AOA, that's the honor medical society.

Q. After you completed your medical school, did you do an internship?

A. Yes. I had an internship in Los Angeles, California, a residency of medicine at the University of Colorado in Denver.

Q. By the way, is cardiology a subspecialty of internal medicine?

A. Yes, it is.

Q. After you finished your training at the University of Colorado at Denver --

A. Then I returned to the University of Pennsylvania as a fellow in internal medicine and gastroenterology.

Q. Did you also serve a tour of duty in the military?

A. Yes, two years on active duty with the U.S.

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Navy. Medical officer stationed for one year on a ship and then for one year in a hospital.

Q. During the time that you went back to Philadelphia for further training, did you become a trainee for the National Institute of Health?

A. Yes. After a year at the University of Pennsylvania, I spent a year in cardiology for the National Institute of Health supported by a fellowship. And I then moved to Miami and had the same position that was -- I had an NIH fellowship in cardiology at the University of Miami.

Q. How does one become a trainee for the National Institute of Health?

A. One applies and competes with other applicants for the position. If you receive the appointment, you're supported for a year to study cardiology.

Q. Are you board certified?

A. Yes, I'm board certified in internal medicine.

Q. When did you become board certified in internal medicine?

A. 1959 and 1960.

Q. At that time, was there a subspecialty board for cardiology?

A. Yes, there was. It was a new board. That was, the idea was to begin to splinter off into groups, and each subspecialty in medicine would have its own board. Initially it wasn't very popular, and I didn't see any need to take the examination, so I never took that examination.

Q. Was there any need to take the examination at that time in order to practice in the field of cardiology?

A. Yes, and there's never been any particular need to take that examination, at least from my point of view, for my position it's nothing helpful.

Q. Now, how was it that you came to Miami from Philadelphia?

A. The University of Miami was a new medical school and they chose as their professor of medicine a faculty member from the University of Pennsylvania. We were friendly, and I asked to accompany him to the University of Miami. And I did so.

So six of us came from the University of Miami, or to the University of Miami from the University of Pennsylvania as faculty members in medicine.

Q. And when you came to the University of Miami Medical School, was it a brand new medical school at

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that time?

A. Yes. The first class graduated either the year that I got here or the next year. So it was a brand new medical school.

Q. When you came to the University of Miami, you came to teach?

A. Yes.

Q. What did you teach at the University of Miami Medical School?

A. Cardiology, which would be heart disease and cardiovascular diseases, diseases of the blood vessels.

Q. How many instructors in cardiology did the University of Miami Medical School have when it first opened?

A. I was the third one. So there were two cardiologists who preceded me. There was a chief and there were two instructors, myself and another doctor.

Q. How long were you a full-time academic teacher of cardiology at the University of Miami Medical School?

A. Thirteen years.

Q. During your 13 years at the University of Miami, did your position change?

A. My responsibilities were the same, but we were gradually promoted from instructor to assistant

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professor and then associate professor. After 13 years I resigned and went into private practice, but I maintained a contact with the University. And I now have the title of clinical professor of medicine, which means I'm a volunteer -- I don't get paid -- but I have a faculty appointment as a clinical doctor rather than as a full-time faculty member.

Q. Is your title clinical full professor of medicine?

A. Yes, they don't put "full," they say "clinical professor of medicine."

Q. What do you teach today at the University of Miami in your position as a clinical professor of medicine?

A. At the present time my responsibilities really are a lecture to medical students about once a month on the risk factors of coronary artery disease.

Q. Why did you decide to leave teaching and go into private practice?

A. The primary reason was I enjoy taking care of patients better than I enjoy working in a medical school. And the opportunity was there at that time and I took it.

Q. During your medical career, I'd like you to just tell the jury briefly about some of the medical or

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professional appointments or positions that you've held.

A. While I was working for the University of Miami I was director of the hypertension clinic, which would be the treatment of high blood pressure. I was director of the peripheral vascular clinic, which would be the diagnosis and treatment of vascular disease.

At each hospital, I've served on various committees. That would include at Bascom Palmer, I was chief of medicine and cardiology for the first few years of its activity. I was a consultant to cardiology to Eastern Air Lines. At Cedars, I've been on a variety of committees. I'm on the panel for reading electrocardiograms and at the admissions committee for University of Miami for several years.

Q. Which hospitals do you have staff privileges at?

A. At the present time I work only at Cedars Medical Center.

Q. Have you had staff privileges at other hospitals?

A. Yes. I've been on the staff of Jackson, Bascom Palmer, and the Veterans Administration Hospital, and at one time Victoria Hospital.

Q. I'd like you to tell the jury a little bit

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about your current practice. I know you told us you have a full patient load. What is the nature of your medical practice?

A. It's primarily an office practice. We have office hours five days a week. We admit patients to the hospital when they're sick, and then we care for our own patients in the hospital.

Q. We've heard the term "invasive cardiology"; what is invasive cardiology?

A. It refers to people who perform procedures that are invasive in the sense, for example, passing a catheter into the heart, inflating a balloon to cause the vessel to be wide open; doing cardiac surgery would obviously be invasive, but those physicians would be referred to as cardiac surgeons. I don't do invasive cardiac surgery.

Q. What types of medical testing do you do in your practice?

A. In the office we take a history, do a physical examination. We perform electrocardiograms, chest x-ray, laboratory values, echocardiograms, pulmonary function. And within the hospital or in other laboratories we do treadmill stress testing; that is, stress testing by walking on the treadmill or by chemicals.

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Q. In your practice do you exclusively see patients with either some form of heart disease or cardiovascular disease?

A. No. I have still a practice that includes internal medicine. I would say 20 percent of my patients have diseases other than the heart or cardiovascular system. And a number of patients come for checkups, they really don't have any disease. And I have a fair number of patients in whom I identify risk factors, and it's really preventive cardiology that I'm practicing. They don't have heart disease. I just don't want them to get heart disease.

Q. Dr. Gilmore, would you give us an idea of approximately how many patients with some form of heart disease that you have seen during your career as a cardiologist?

A. Well, I've been in practice a long time, since 1959, as a cardiologist. And I would say that I've seen eight to 10,000 patients with cardiovascular disease.

Q. When you were a full-time faculty member at the University of Miami, I assume that as part of your academic responsibilities you kept up with all the current medical literature in your specialty of cardiology?

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A. Yes, I did.

Q. Have you continued to do that since you've been in private practice?

A. Yes, I do. I read the medical journals, I subscribe to two services that abstract medical literature. We have a weekly cardiology meeting at Cedars Medical Center. And I attend other medical educational meetings.

Q. How would you say that your study of the literature in cardiology compares to most practicing physicians?

A. I think, compared to practicing physicians, I have a greater opportunity to see the literature, and I certainly think that I work at it a little harder. The medical library at Cedars is adjacent to my office, or it's in the next building and I can go there every day to read literature if I need to.

Q. Dr. Gilmore, we're going to be talking this morning about some concepts of heart disease, cardiovascular disease. I'd like to begin by having you explain some basic concepts for the jury so they can follow along with us. In that regard, have you helped me prepare some demonstrative exhibits?

A. Yes, I have.

Q. Let me put the first one up here.

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With the Court's permission, Dr. Gilmore, feel free to come down and point things out on the board. Here is a pointer if you need it.

And let me ask you first if you could, using this, describe for us the types of blood vessels in our body and their role in our body.

A. You can see it's a picture of the human body, and the red lines represent the arterial blood system. The heart is the central pump, it pumps blood out the aorta, and all these branches go to all the peripheral tissues. It then passes through capillaries where it discharges oxygen, picks up carbon dioxide, and returned by a venous system, which is usually shown in blue, which would be parallel to this arterial system.

Q. If we're talking about the arteries in the area of the heart, what do we refer to those as?

A. The arteries all have individual names, but in general, the arteries to the heart are called the coronary. The arteries to the brain are cerebral vascular bed, "cerebral" referring to brain. Arteries that are distal to the body are generally called peripheral, so the arms and legs would be the peripheral arteries.

Q. Now, you've told us, of course, that the centerpiece of all of this is the heart, and I want to

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talk a little bit more specifically about the heart. So let me put this down and put up the next one.

Again, you helped us prepare this demonstrative aid?

A. Yes, I did.

Q. Describe for the jury, if you would, please, the heart and the major portions of the heart and their functions.

A. There are three pictures. They all show the same view of the front view of the heart.

And if I go to the center one, this is the heart, illustrated in red would be the aorta, the major vessel coming from the heart. And it's from this aorta that all the branches supplying the body derive. It's illustrated by showing the right coronary artery and the left coronary artery.

The dark gray would be the heart muscle. The light gray would be the cavities of the heart, and the labeling is really for the coronary arteries.

If we go to the drawing on the left, it's a little more colorful because it shows the veins. That is the blood coming back to the heart has no oxygen, and it's blue. Once it picks up the oxygen, it's colored red.

From the upper part of the body, the superior

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vena cava, from the lower part, the pulmonary trunk. It comes into the chamber of the heart and goes to the lungs, out through the pulmonary artery, still blue, picks up oxygen in the lungs, comes back through the left pulmonary vein and the right pulmonary vein. Now it's red. It goes back into the heart and into the aorta as I showed on the first drawing.

You can see that the veins returning from the blood from the coronary arteries are parallel, but they're colored in blue. This drawing shows that the heart has been bisected so that you look into the chambers. The structures are the same, but inside the heart there are valves. There are four chambers and four valves. Each valve separates the chambers so that the blood won't go backwards; it maintains forward flow of blood.

Q. Now we've also heard something called the conduction system of the heart. What's the conduction system of the heart?

A. That's not shown on this drawing, but the heart has an automatic conduction system, a primary pacemaker that is subject to influence, so that it can go faster or slower. And from that pacemaker, there's -- the best analogy would be an electrical system, there is a system called the conduction system

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that generates an electrical impulse that causes the heart muscle to contract. So there are diseases of which the conduction system doesn't function normal.

Q. What is the normal number of times that our hearts beat?

A. Under resting conditions, the normal rate is 60 to 100 beats per minute.

Q. And I'm sure jurors have heard you mention the word electrocardiograms. What's an electrocardiogram?

A. You can measure the electrical current that goes down the conduction system. It's called depolarization. It's an electrical impulse that causes the heart muscle to contract. And it generates a current that can be picked up on the body surface, so you can put wires on the arms and legs, hook it up on a galvanometer, and it will generate for every heart beat a graph of that electrical impulse causing the heart to contract.

Q. Thank you, Dr. Gilmore.

I want to talk to you next, Dr. Gilmore, about cardiovascular diseases. First of all, in general, what is a cardiovascular disease?

A. That would be an abnormality or pathology, some abnormality of the heart or blood vessels.

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Q. Now, is there just one disease that is known as cardiovascular disease or are there many?

A. No, any disease that involves a heart or blood vessel would be called a disease of the cardiovascular system, or it would be called heart disease.

Q. And again, is there one heart disease?

A. No, there are many.

Q. When you see a patient in your practice and determine that a patient has some heart problems, would you ever give a diagnosis that's just heart disease?

A. No, my responsibility is to try to determine what kind of heart disease it is, because the treatments and the prognosis, that is the future, depends upon what the specific kind of heart disease is.

Q. And do the risk factors for different types of heart disease also differ?

A. Yes. Each kind of heart disease would have its own set of risk factors.

Q. Okay. Dr. Gilmore, what is a risk factor?

A. A risk factor is generally a statistical association between an event and a result. So it's usually just based on statistics.

Q. In general, again talking broadly about

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cardiovascular diseases in general, are they considered to be multifactorial diseases?

A. In general, most heart diseases are considered to have many risk factors, and therefore they're called multifactorial.

Q. We've heard references to risk factors in this trial, as you've just said. You also just mentioned that that's related to association, statistical associations. If something is a risk factor, does that mean in your opinion that the factor causes the disease?

A. No. Many years ago, at least for arteriosclerosis, many years ago it was decided that we didn't know the cause, it wasn't decided by me, but by cardiologists, they had a meeting and said: We don't know the cause, and they said: It might be better if we called these factors "risk factors," and if we could document and study the risk factors, perhaps we could solve the problem for heart disease.

Q. When you see patients for any type of heart disease, do you routinely assess the patients for risk factors?

A. Yes. I do the best I can to identify all the risk factors that exist.

Q. And generally, how does medical science

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determine that something is a risk factor for disease such as cardiovascular disease?

A. As I said, there's a statistical correlation. There are a lot of studies to try to make it more certain than just association, that is, intervention studies in which you take away the risk factor and see if the disease disappears, animal models, to see if you can reproduce or cure the disease in animals.

And one would like to have a biological association, that is, one would like to be able to say that this risk factor is causal because of this mechanism. So we would like to know a mechanism by which the risk factor might cause or result in heart disease.

Q. Next I want to turn to the subject of cardiovascular diseases and specifically heart diseases. You told us that there were many of those. And again, have you helped us prepare a chart of various heart diseases that you deal with in your practice?

A. Yes, I have.

Q. Is this that chart?

A. Yes, it is.

Q. Now, heart disease would be one type of cardiovascular disease, correct?

A. That's correct.

Q. And up here on this board we have types of heart diseases, and I want to talk to you about these.

Let me first ask you this question, then we're going to go through each one of them and talk about them specifically. But in terms of the number of diseases that you have on the board, are most of these diseases on this chart statistically associated with cigarette smoking?

A. No, most of them are not.

Q. All right. Let's go through them and talk about which ones are and which ones aren't.

First we have on the board: Diseases of the Muscle. And you told us, while we were looking at this diagram of the heart, that the dark gray outline of the heart is the heart muscle.

Are there actually diseases of the heart muscle, itself?

A. Yes. And that's the first one up there, Cardiomyopathy, would just be a term that refers to, "myo" is muscle, so cardiomyopathy is pathology or abnormality, disease of the heart and muscle.

There are many causes of cardiomyopathy, but, for example, myocarditis would be an infection either with bacteria or, more likely, virus; so viral

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myocarditis would be a form of myopathy.

Q. Is cigarette smoking considered to be a risk factor for the development of either of these diseases of the muscle, that is, cardiomyopathy or myocarditis?

A. No.

Q. Next you told us about, on your diagram of the heart, the heart valves. Are there diseases of the heart valves?

A. Yes. And there are three listed there. There are many diseases of the heart valves. At one time diseases of the heart valve due to rheumatic fever was probably the commonist cause of heart disease in the world. But at the present time, with the control of infection, that's much less important.

So the three that I've listed there, mitral valve prolapse, which is very common, the one that involves the valves in the heart is called the mitral valve. If it buckles or leaks it's called prolapse. It occurs in perhaps 10 percent of women. So it's a common ailment.

Aortic stenosis would be a different valve, the aortic valve, which is the valve that allows the blood to go out the aorta to the body, and stenosis means it's too tight. So when you have a tight aortic valve, that's called stenosis. That's common. It may

occur at birth or it may develop due to age.

Mitral valve regurgitation could be a number of things. But, "regurgitation" means the valve leaks, it's not competent. Some of the blood flows through it, but during the next part of the heart cycle the blood goes backwards, so it's a defective valve function.

Q. Is cigarette smoking considered to be a risk factor for any of these diseases of the heart valves?

A. No.

Q. Next on the board we have something called the endocardium. What's the endocardium?

A. The endocardium is the lining of the heart, three layers. The endocardium is the lining. The myocardium is the heart, that's the muscle. And the next one you'll see is the pericardium, which is a sac around the heart.

So there are three layers. Endocardium can be infected, it can be infected by bacteria.

Q. Is cigarette smoking considered to be a risk factor for the development of endocarditis?

A. No.

Q. And are there also diseases of the pericardium that you just spoke about?

A. Yes. The sac around the heart is a

pericardium. I've mentioned pericarditis, which would be an inflammation, mainly viral. I've mentioned cardiac tamponade, which means that there's too much fluid in the cardial sac, and it embarrasses the heart function. It can come from trauma, usually gunshot wound, a stabbing wound or infection.

Q. And is cigarette smoking considered to be a risk factor for any of these diseases of the pericardium?

A. No.

Q. Next we have the conductive system, which you told us about as you were describing the operation of the heart. Are there diseases of the conductive system of the heart?

A. Yes. I called that arrhythmias. The normal heart function is normal rhythm. If it goes too fast or too slow, it's called an arrythmia. It's often a result of the disease of the heart. It's usually degenerative. It can come from other factors, but the arrythmia itself can be a primary problem.

Q. Is cigarette smoking considered to be a risk factor for the diseases of the conductive system of the heart?

A. No.

Q. Next you have something called congenital

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heart disease, and while that may seem somewhat self-explanatory, tell us what that is.

A. Congenital means you're born with it. So when a child is born, he may have a defect in the heart, usually a hole in the heart, sometimes an abnormal valve. But all kinds of abnormalities of the heart, conductive system, can all be congenitive, they can occur at birth.

Q. We've seen, seems like examples just in the Miami area, recently, you read in the paper, say, about a young high school basketball player seems perfectly healthy, then collapses on the court.

Are those usually a result of some sort of congenital heart disease?

A. Almost always due to congenital abnormalities. They're born with it, but it's not readily apparent, it doesn't cause symptoms, and it results in sudden death.

Q. And would cigarette smoking be considered a risk factor for congenital heart disease?

A. No.

Q. Now next we say here Tumors of the Heart. And Dr. Gilmore, is it actually possible to have cancer of the heart?

A. Yes. You can have tumors or cancer that

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develops in the myocardium, that would be the heart muscle, or in the pericardium.

Q. Would these be a primary cancer, in other words, a cancer that began in the heart?

A. Yes.

Q. Is cigarette smoking considered to be a risk factor for the development of primary cancers in the heart?

A. No.

Q. Next we have something that I'm sure most of us have heard a lot about in our lives, Hypertension. What is hypertension?

A. Hypertension simply means high blood pressure.

Q. And is cigarette smoking a risk factor for the development of hypertension?

A. No.

Q. Next we have Embolisms. What are those?

A. You'll see there, Embolism and Thromboembolism. If a clot forms in the vessel, it's called a thrombus. If it goes downstream and blocks the artery, it's called embolus. So thrombosis would be the broken-off clot. And if it goes to the lung, it's called a pulmonary embolus.

It can happen in any part of the circulation.

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It's just that pulmonary emboli, that is multiple embolisms, are a fairly common form of embolic disease, breaking off clots.

Q. Now, I notice that we mentioned here pulmonary embolism. Is that a cardiovascular disease, something that's within your practice?

A. Yes.

Q. Let me also ask you about something else that we don't have up on the board that we've heard something about during the course of this trial: phlebitis.

A. Phlebitis means inflammation, the word "itis" always refers to inflammation. And "phlebitis" would be a vein. So phlebitis is inflammation of a vein. It's accompanied by a thrombus, or clot. So the disease really is that the vein gets a clot, and it's inflamed, it's red and warm and it hurts.

Q. Is cigarette smoking considered to be a risk factor for the development of any of these embolisms or phlebitis that you've just told us about?

A. No.

Q. Next item on the board is Congestive Heart Failure. What is congestive heart failure?

A. If the heart muscle fails to pump enough blood to nourish the tissues of the body, those tissues

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won't function normally. And that's called heart failure.

One of the compensatory mechanisms, one of the things the body does to help that is to retain fluid. So there's often swelling of fluid in the feet or accumulation of the fluid in the lung. It's called congestive heart failure. It's kind of the end stage of most of these diseases. If they are advanced and progressive, then you'll develop heart failure.

Q. And is cigarette smoking considered to be a risk factor for congestive heart failure?

A. It's not specifically related to cigarette smoking. It's not -- cigarette smoking is not a risk factor for the progression to congestive heart failure.

Q. The next item on the board is Aortic Aneurysms.

A. I mentioned the aorta is the major blood vessel that comes from the heart. And if it's weakened or swollen or dilated, it's called an aneurism. And frequently, because it is dilated, it's weak. And it may burst. So that would be a catastrophe. The patient would usually die suddenly.

Q. Is cigarette smoking considered to be a risk factor for the development of aortic aneurysms?

A. No. The common cause is degeneration of the

middle part of the blood vessel.

Q. Dr. Gilmore, up to this point on your chart, all the diseases we have looked at, in your opinion, none of these are statistically related or, to put it another way, cigarette smoking is not a risk factor for any of the diseases we've talked about so far; is that correct?

A. Cigarette smoking is not a risk factor for any of those diseases.

Q. Now, let's move on to the next one. The last one that we have up here is Diseases of the Vessels or Arteries.

Do heart diseases originate in the arteries?

A. Yes. These are the arteries that nourish the heart. They're called the coronary arteries. Because the heart is such an important organ, these vessels are very important vessels.

Q. Dr. Gilmore, in terms of number of patient whose might have some form of heart disease, are diseases of the arteries the most common?

A. They are the most common. In this country and in many countries, arteriosclerosis, or disease of the coronary arteries, is the most common.

Q. And you just used a word that I want you to define, tell us what it is. What is arteriosclerosis?

A. Arteriosclerosis literally means hardening of the artery. The word "sclerosis" is hardening of the arteries.

Q. We've also heard witnesses in this case use a similar sounding word, "atherosclerosis." What is atherosclerosis?

A. To be precise, atherosclerosis is a little bit different. Hardening of the arteries means that it's stiff and hard. It's no longer as flexible. Atherosclerosis refers to a disease on the inside of the vessel --

Q. Have you actually prepared a graphic here that can show this?

A. Yes.

Q. Why don't I put this up and why don't you use this as you demonstrate for us atherosclerosis.

A. That's a normal blood vessel. It's been cut across.

The red part would be the outer wall of the blood vessel called the adventia.

The media would be the middle part. And it's muscle.

The lining is like Teflon. It's called the endothelium. It's meant to be very smooth so that the blood can travel without any resistance and there won't

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be any clotting formation.

The atheroma or atherosclerosis means that there is a small tumor, "oma." That's made up of cholesterol. So this is atherosclerosis, the development of cholesterol in the lining of the vessel.

Arteriosclerosis really meant hardening of the other layers of the vessel. But it's frequently, in lay terms and in medical terms, used interchangeably. So unless one is being very precise, atherosclerosis and arteriosclerosis would be the same thing.

But the real disease that blocks the vessel, atherosclerosis, a plaque forms made up of cholesterol, calcium as it gets older, and fibrous or scar tissue.

Eventually you can see, in the bottom layer, that this might totally occlude the vessel. The blood will no longer flow through this lumen. And the tissue would have no oxygen, no blood, and would die. If it's the heart, that's called the myocardial infarction or heart attack.

Q. Tell the jury, please, who gets atherosclerosis.

A. Everybody gets it. It's common. In fact, I have to say it's universal in this country. In people who die from trauma, that is, not from heart disease or

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any other disease, even in childhood there are plaques or there are arteriosclerotic changes, usually in the endothelium, so the disease starts very early. Then it's slowly progressive over many, many years.

But when you get to the teens and early twenties, for example, the servicemen who were killed in Korea and Vietnam, and their hearts were autopsied or examined, there was substantial disease in those arteries.

Q. When does arteriosclerosis, since we all have it, become a medical problem?

A. Unless you get symptoms, nobody cares that they're being narrowed. There are a lot of vessels and they have collaterals; that is, if one gets blocks, the blood can go by another pathway. Usually we say that a vessel that causes symptoms is significantly obstructive.

Sometimes patients are catheterized or their arteries are examined, and they don't have symptoms but they'll have an obstruction of 60 or 70 percent. As it begins to be that amount, we begin to think that's significant. In other words, up to 50 percent, we don't think it's significant; over 50 percent becomes progressively more risky.

Q. Now, going back to our original diagram, the

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arteries of the body, I want to talk to you about, now, which arteries of the body may be affected by atherosclerosis, even to the point of it becoming a medical problem.

A. The ones we talked about are the coronary arteries, which would be the ones up there that are nourishing the heart. So that's the commonist to be involved, and it is certainly important.

Q. So that would be these here?

A. Yes. If they go to the head, they're called the cerebral vascular arteries.

Q. These?

A. Yes, all the way up to the head. As I said, if you have an obstruction in a coronary artery, you get a heart attack. If you have an obstruction in the coronary artery to the brain, you get a stroke. The brain tissue nourishing that artery dies and the function of that brain tissue is gone. So if it made the arm move and it's dead, you will have paralysis of the arm.

For both the brain and the heart, that's generally irreversible. The dead tissue does not come back to life and it cannot be replaced.

Q. And if you have occlusion of the cardiac arteries to the point of it being a problem, what do

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you call that?

A. Before a heart attack, one may develop pain, usually on effort or stress. That is, as the vessel becomes narrowed, the heart muscle is not getting enough oxygen and it hurts, that's called angina or angina pectoris. If you rest or avoid the stress, the pain usually goes away in five or ten minutes. So it's temporary, no harm done, but a very serious warning that that vessel is at critical levels in terms of its lumen diameter. If the vessel completely occludes and there are no collaterals, the heart muscle dies, and that's a heart attack.

Q. And in terms of name of the disease, what do we call those diseases relating to the coronary artery?

A. That's coronary artery disease, myocardial infarction, angina pectoris, all terms relating to the disease of the coronary arteries.

Q. What would we call a disease that relates to the arteries going to the brain?

A. That's cerebral vascular disease.

Q. What would we call a disease that relates to the arteries going to the arms or legs?

A. That's called peripheral -- it's outside the trunk -- vascular disease, peripheral vascular disease.

Q. Is the atherosclerotic process that you've

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described for us and shown us, is it the same whether we're talking about coronary artery disease, cerebral vascular disease or peripheral vascular disease?

A. It's the same process, it happens more in some vessels than in others, presumably related to pressure flow relationships and stress on the vessel wall, but much more common in the coronary arteries than in the cerebral vascular, then in the legs rather than the arm, and that would be peripheral arteries.

Q. Now, Dr. Gilmore, is cigarette smoking considered to be a risk factor for the development of atherosclerosis?

A. Yes, it is.

Q. And in your practice you consider cigarette smoking to be a risk factor?

A. Yes, I do.

Q. You told us earlier about things like animal models and studies such as that. Have there been any laboratory studies that confirm a relationship between smoking and atherosclerosis?

A. There are no animal models that have demonstrated that smoking can cause the atherosclerotic process in animals.

Q. Now, you told us a little bit about a stroke and that could be the consequence of atherosclerosis in

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the cerebral vascular arteries, correct?

A. Yes.

Q. What exactly is a stroke?

A. A stroke means an infarct, death of tissue in the brain.

Q. Is there more than one type of stroke? Just as we talked about more than one type of heart disease, is there more than one type of stroke?

A. Yes. When I say "stroke" and it's death of brain tissue, it's death of brain tissue due to a vascular catastrophe or accident. So as in the types of thrombosis, in the brain it's not infrequent to have hemorrhage, usually related to high blood pressure, the blood pressure that could be called a hemorrhagic stroke, the first one was a thrombotic stroke. And can you develop clots that go to the brain that come from some other part of the body and those would be called an embolic stroke.

Q. So three types of strokes, embolic, thrombotic and hemorrhagic. Did I get that right?

A. Yes.

Q. Now, is smoking considered a risk factor for all three of these types of strokes?

A. It's a risk factor for thrombotic. It's not a risk factor for hemorrhagic, which I said is usually

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due to hypertension. And it's probably not a risk factor for thrombotic, it would depend where the embolus came from.

Q. Thrombotic stroke, that's the one that's related to this atherosclerosis process?

A. Yes.

Q. Now, you've also told us that we have something that we generically refer to as peripheral vascular disease, and that relates to diseases of the arteries outside the trunk, correct?

A. Yes.

Q. Now, as a cardiologist, do you also study and treat peripheral vascular diseases?

A. Yes, I do.

Q. What would be the symptoms of peripheral vascular diseases?

A. It's similar to the heart. That is, as the vessel narrows, there's not enough blood going to the leg, and when you need oxygen for walking or running, there won't be enough, and pain develops, and you have to stop and rest. And the pain will then go away.

So I described angina as pain in your heart when you're not getting oxygen. You can get pain in the leg when you're not getting oxygen. And it's relieved by rest.

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Q. And as we talked about with respect to heart diseases, are there different types of peripheral vascular diseases?

A. Yes, there are. The common one would be arteriosclerosis, but you can also have embolic and hemorrhagic, which would be uncommon. But in the legs you can also have inflammatory diseases of the arteries, which are usually not related to arteriosclerosis. So the diseases in the legs, that's, the commonist would be arterial or atherosclerosis. But there are other forms of arterial diseases to the legs.

Q. Is cigarette smoking considered to be a risk factor for any of the peripheral vascular diseases other than arteriosclerosis?

A. No.

Q. Is there, in your judgment, Dr. Gilmore, something called Buerger's disease? Have you ever heard that phrase?

A. Yes, Buerger is a man's name. He initially described an occlusive, a blockage of arteries that was unusual because it occurred more in the upper extremities than the lower extremities. Pathologicly it was inflammatory rather than just atherosclerotic, and was often associated with phlebitis, inflammation

in the veins.

Q. And is Buerger's disease related to atherosclerosis also?

A. There's great debate about what Buerger's disease actually is. Because when it was initially described -- it's a very rare disease. It was initially described in New York, and it was thought to occur in men who smoked. It's now known that it can occur in nonsmokers and in women. But its incidence is decreasing and, as I say, there's debate as to what the nature of Buerger's disease is. I think it's probably a variant of atherosclerosis and not a totally independent disease.

Q. All right. So then when we talk about coronary artery disease, cerebral vascular disease or peripheral vascular disease, is cigarette smoking a risk factor for any of them other than the ones relating to atherosclerosis?

A. It's a risk factor for atherosclerosis only. The others are not.

Q. Let's then talk more specifically about atherosclerosis and risk factors.

Would the risk factors for the development of atherosclerosis be the same regardless of whether we're talking about the cerebral, peripheral or coronary

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arteries?

A. Yes. There's some variation in the degree of risk, but they all are the same and they overlap.

Q. And would there be multiple risk factors then for the development of atherosclerosis regardless of which of the arteries we're talking about?

A. Right. In any vascular bed there are a variety of risk factors.

Q. Is one of the risk factors cigarette smoking?

A. Yes, it is.

Q. Have you helped us prepare a chart listing some of the principal risk factors for atherosclerosis?

A. Yes, I have.

Q. And first, before we go specifically through these, let's start with how an individual attains a risk factor. I notice that your chart refers to nonmodifiable and modifiable risk factors. Tell us what that concept means.

A. Well, it's important clinically to identify the risk factors, then to correct the risk factors. And when we say "nonmodifiable," we imply that you can't fix it, that it's there, and it's more or less something that I cannot advise the patient to change. So it's fixed.

"Modifiable" are the things that I expect

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between myself and my patient to be able to change, try to reduce or get rid of this risk factor.

Q. Before we go through these specifically, let me ask you this question: If an individual has one or more of these risk factors in their background, in their history, when you take a medical history, does it mean that the individual is going to develop either coronary artery disease or peripheral vascular disease or cerebral vascular disease from atherosclerosis?

A. No, it's not predictable, it's not inevitable. People who have risk factors may live their entire life without any vascular disease. And the converse is true as well. So the risk factors help you, but they're not the only thing.

Q. Let's talk briefly, specifically, about these risk factors, and start with the nonmodifiable risk factors. Just tell us what these are.

A. Gender would be male or female. Males have a higher risk factor, so when they talk about risk factors, just being male is a risk factor.

And for women beyond the menopause is a risk factor. Presumably the hormones during the younger years of a female's life are protective, but when they're gone, then that protection is lost.

Family history would refer to heredity. If

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there's a member in a family, particularly a parent, that has coronary or vascular disease, then the offspring are more likely to have it.

Age, it's a progressive disease. As I told you earlier, it starts at a young age and progresses, so the older you are the more likely you are to have vascular disease.

And ethnic background refers to the belief that certain races tend to have less coronary disease or arteriosclerosis.

Q. Okay. Let's now turn to the modifiable risk factors. You told us what that means. What are the principle modifiable risk factors for atherosclerosis?

A. This is a long list and it's not complete, and I didn't pick them in any particular order. I don't mean to say that some are more important than others. And what's important to know is that these risk factors change from year to year. For example, sometimes coffee is on that list. And I heard on the radio today that there's a study that says coffee --

MR. ROSENBLATT: Objection about what he heard on the radio.

THE COURT: Sustained.

THE WITNESS: The first one is hyperlipidemia, which is high cholesterol. It's

modifiable by diet or by pills.

The second one is diabetes, that's an intolerance to sugar metabolism.

High blood sugar, that's modifiable by diet and pills and injections.

Stress or personality type would be the external event of stress and the personal response to that event.

Obesity is overweight. It's an independent risk factor.

So I've listed obesity, diet and cholesterol. Each one is a risk factor. And they're kind of interdependent, because if you're obese, you usually have a bad diet and high cholesterol. But these are each listed as an independent risk factor.

Sedentary lifestyle would be a non-active lifestyle.

Homocysteines is a component of protein metabolism. Bacterial infections, people have identified bacteria within the atheroma, and they've shown that an allergy to that bacteria and a treatment for that bacteria can alter the development of disease.

Smoking we've talked about that there's a statistical relationship between smoking and atherosclerosis.

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Alcohol in larger doses is thought to be a risk factor, there's now evidence that it may be protective in small doses.

Depression, that is, emotional changes such as stress or depression, contribute to a higher rate of atherosclerosis.

High blood pressure puts a greater strain on the blood vessel and results in a higher risk factor.

And I put uric acid on because there is a strong statistical relationship but no evidence that reducing the uric acid is protective, although there are studies now underway to evaluate the role of uric acid.

Q. Have you listed all of the risk factors for atherosclerosis on this board?

A. No.

Q. How many, to your knowledge, have been reported in the medical literature?

A. Over 200 risk factors have been named. That is, that there's a statistical correlation between a factor and the result. It doesn't mean that they're caused, but it means that there is a relationship.

Q. In your judgment, are there unknown risk factors that science hasn't discovered yet?

A. I believe there are. For example on that

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list, homocysteine is a relatively recent popular risk factor.

Q. Dr. Gilmore, looking at this chart, looking at all of these risk factors, in your opinion has it been scientifically proven that any of these risk factors, and I'm including within my question cigarette smoking, has it been shown that any of these risk factors cause atherosclerosis?

A. I don't believe it's proven. In a number of studies, more than 50 percent of people who get a heart attack don't have any risk factor that's known. They don't have these risk factors and yet they develop heart disease, heart attack, atherosclerosis.

Q. Why do you say that it hasn't been scientifically proven that any of these risk factors cause atherosclerosis?

A. As I say, if you can develop heart disease without a risk factor, it would indicate to me that there are other factors that we don't know about. And as long as I don't know the other factors, then it's hard to judge what their importance is. And in none of these cases has it been shown uniformly that everybody with a risk factor gets it and everybody without a risk factor doesn't get it.

Q. You told us earlier about animal studies, you

told us about mechanism. Is there ongoing research in the areas of animal studies an ongoing research into the areas of mechanism with respect to atherosclerosis?

A. Yes, there are studies on probably every one of these risk factors in terms of modification and mechanism.

Q. And why is it important to continue to have that kind of research?

A. Because it's a very common disease. It's the most common disease in this country.

Q. And what type of research, Dr. Gilmore, in your judgment, is necessary in order to prove the cause of atherosclerosis?

A. Well, the epidemiologic studies are important, but more important are probably the laboratory study, not just animal models but laboratory studies on human beings that would develop a reasonable mechanism, something that made sense as to how the risk factor actually causes the disease.

Q. When you use the word "mechanism," are you referring to the actual process by which any of these risk factors might cause this to happen in an artery?

A. Exactly. We don't know exactly why this develops. People use the term "biologically plausible." We need a plausible mechanism that

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explains how the process develops.

Q. You also mentioned earlier something called intervention studies. Again, have there been intervention studies of the various risk factors for atherosclerosis?

A. Yes, since before the use of the word "risk factor," people have tried to modify the disease by changing the risk factors. And in general it's been disappointing, that is, studies in which you intervene and you change diet or blood pressure or smoking or lifestyle, have not given, in many cases they haven't given improvement at all. And they have not uniformly shown improvement, that is, a reduction in the rate of the disease.

Q. If you were to look at someone's arteries under a microscope and you found atherosclerosis that had proceeded to the point of being a medical problem, could you tell from looking at it which, if any, risk factors that individual had?

A. No, the process looks identical regardless of the number of risk factors or the absence of risk factors. The pathological examination of the vessel is the same in each case.

Q. Could you tell, if you looked at the arteries of someone like this, whether that person was a smoker?

A. No.

Q. Do you have to have any of these risk factors in order to develop atherosclerosis?

A. You do not. As I mentioned, more than 50 percent in some studies have shown the absence of these risk factors. And, in fact, in the general population, in the United States, although the risk factors are decreasing, that is, there is treatment and we do try to modify the risk factors, the number of new myocardial infarctions or heart attacks has really not decreased.

The death rate goes down because the treatments have improved. What they call secondary prevention has gone down because you're less likely to get a second attack. But new heart attacks have remained the same so we still have a big problem.

Q. If a patient came to you and you took the patient's history fully, and you found that in that patient's history he or she had only one risk factor, only one thing on this list or even in the list of 200 in their history, whatever it is, under those circumstances, would you be able to conclude that that risk factor caused the patient's cardiovascular disease?

A. No. I could not identify which risk factor,

even if there's only one, if that's the cause, because as I said, there are risk factors that I don't know about.

Q. If a patient had two or more of these risk factors when you took a history, would you be able to tell which risk factor was more important to the development of that patient's cardiovascular disease?

A. No, I don't.

Q. You've told us today, Dr. Gilmore, that it hasn't been scientifically proven that any of these risk factors, including smoking, cause atherosclerosis. You've referred to them as a risk factor. Is this merely a semantic difference to call something a risk factor as opposed to cause?

MR. ROSENBLATT: Object as leading, Your Honor, without recapitulation and the predicate for the question.

THE COURT: Overruled.

BY MR. ROSS:

Q. Go ahead.

A. I should answer?

Q. Yes.

A. No, I think it's more than just semantics. That is, to all of us "risk" sounds not as certain as "cause." I think the terms are used interchangeably by

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lay people and doctors as well. But I think when it was decided by cardiologists that we would call them risk factors, it was done with the purpose of saying more research needs to be done, we don't know the cause, and it continues to be used in that fashion. And every month there are journals with articles saying: We're studying risk factor.

Q. In your judgment, which is the appropriate term?

A. I believe it should be risk factors.

Q. All right. We'll come back for a few more questions about this in a moment, but I want to just give you a couple of questions about another part of your practice.

You did tell us that, I believe, about 20 percent of your practice involves internal medicine issues other than cardiovascular; is that correct?

A. Yes.

Q. In the course of your regular practice, do you treat patients with either peptic ulcers or osteoporosis?

A. Peptic ulcer disease or stomach ulcers I treat. Osteoporosis, which is thinning of the bones, I treat not as frequently. But yes, I give medication for both.

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Q. Is cigarette smoking considered to be a risk factor for the development of osteoporosis?
A. I don't believe it's a risk factor, that -- there is probably a statistical correlation.
Osteoporosis occurs in older people. The risk factors are physical inactivity. Most smokers are not as active as non-smokers. And that's probably the connection. I don't even know what the statistical relationship is. But the cause of osteoporosis or thinning bones is really related to physical activity, hormones, the intake of calcium and vitamin D.
Q. And is cigarette smoking considered to be a risk factor for the development of peptic ulcers?
A. Not any more. That is, peptic ulcer disease, stomach ulcers, at one time was said to be a multifactorial disease related to the risk factors of alcohol, smoking, anxiety, tension, poor diet, et cetera.
Some years ago a bacteria was found that's now known to be the cause of peptic ulcer disease. You can cure it with an antibiotic. If the antibiotic is successful in eliminating that, it will not recur. So the peptic ulcer, the acids that cause that disease, are not due to cigarette smoking.
Q. Dr. Gilmore, what do you tell your patients

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about smoking?

A. I tell them to stop smoking, that it's a risk factor. I want them to be in the low risk group, and I try to correct all those risk factors, including smoking. Smoking, I ask them please stop.

Q. Have you ever told a patient that if they don't stop smoking, they will develop atherosclerosis?

A. I don't make any guaranties, but I emphasize to the patient the importance of lifestyle changes, which would include stopping smoking.

Q. Have you ever told the patient if they do stop smoking they won't develop atherosclerosis?

A. No. Again, there are no guaranties.

Q. Are you aware, Dr. Gilmore, that there are physicians, many physicians in the public health arena, and again many public health agencies in this country, that say smoking causes atherosclerosis or it causes heart attacks? Are you familiar with that?

A. Yes.

Q. Do you take issue with people in the public health arena who say that?

A. Well, it depends on the circumstances.

In the public health point of view, since smoking is a risk factor, I agree that they should say: Stop smoking. But they're not being scientific and

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they're not giving a balanced view of the evidence. Instead of saying smoking is a risk factor, you should stop, they're saying smoking is a cause, you should stop. So I take issue with their conclusion.

Q. Dr. Gilmore, if someone representing a tobacco company were to take the public position that it has not been scientifically proven that smoking causes atherosclerosis, heart disease, stroke or peripheral vascular disease, in your opinion, is that statement true and reasonably based on science?

A. I agree, it's not scientifically proven as a cause.

MR. ROSS: Thank you. No further questions.

THE COURT: Okay, let's take a short break at this point.

(The jurors exited the courtroom.)

THE COURT: During the break you must not discuss your testimony with anybody including the lawyers.

THE WITNESS: Thank you.

(Thereupon, a recess was taken.)

THE COURT: Okay. I guess everybody is here that's suppose to be. Bring the jury out, please.

(Thereupon, the jurors exited the courtroom.)

THE COURT: All right. I think everybody is

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here. We may proceed with cross.

CROSS EXAMINATION

BY MR. ROSENBLATT:

Q. Good morning, ladies and gentlemen.

Good morning, Dr. Gilmore.

A. Good morning.

Q. You're obviously located here in Miami?

A. Yes.

Q. You testified that you took the boards for internal medicine when, in '59 or '60?

A. Yes.

Q. One --

A. I think I took it in '59, got the results in '60.

Q. Then you testified that the boards were available to be taken in the field of cardiology, you simply chose never to take the boards, correct?

A. That's correct.

Q. Now, you know the jury has heard a lot, there's a lot of honorary stuff in medicine, but when we talk about board certification, that involves a doctor, a full fledged M.D. who wants to practice a given specialty as you did with internal medicine, you sit down and you take oral and written examinations. And if you pass, you're able to represent to your

patients and to the public at large and to your fellow physicians you're board certified in a particular field, correct?

A. That's correct.

Q. And generally speaking it's prestigious, it's more -- you know, if someone says: Yes, I practice internal medicine. And someone says: Well, are you board certified? And the doctor says: No. It sounds better and it's more prestigious if someone says: Yes, I'm board certified. Right?

A. Yes.

Q. Could you explain why in the 40 years since you took the boards for internal medicine, since you represent yourself to be a cardiologist, you never saw fit to take the cardiology boards and become board certified in cardiology? Is that just a matter of choice?

A. It's a matter of choice.

Q. Why?

A. Well, when I came to the University of Miami, they were relatively new boards. And politically, the major society of cardiologists was the American Heart Association, which included lay people as well as doctors. They raise funds and they do research. Then there was a new group that wanted to start the American

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College of Cardiology with boards. The chief of cardiology at the University of Miami did not have his boards, he did not encourage me to take my boards and I was -- I had all the qualifications, and I saw no reason that I to take an examination to do what I was doing. And he saw no reason that I needed to take the examination. I didn't take it.

Q. You would certainly agree that the University of Miami School of Medicine, as most prestigious schools of medicine across the United States, have grown by leaps and bounds in the last 30, 40 years, and things have just changed enormously, correct?

A. Yes.

Q. Someone could not be the head today at the University of Miami School of Medicine, could not be the head of cardiology without being board certified, could he?

A. That's not true. About 50 percent of cardiologists don't take or become board certified in cardiology.

Q. Dr. Gilmore, is it your understanding that at any prestigious medical school in the United States, Harvard, the University of Florida, the University of Miami, Stanford, the University of California, are you telling us -- I'm asking you about the chairman of the

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department of cardiology at a major medical school, isn't it a fact that they are all -- there may be one or two exceptions, but basically they are all board certified?

A. I'll bet that there are one or two exceptions.

Q. Which proves the rule?

MR. MOSS: Let him finish.

THE COURT: Yes, he can finish.

THE WITNESS: In order to take the boards in cardiology you must have your boards in internal medicine. And many prestigious cardiologists have never gone through that. They've started off in cardiology, particularly if they're interested in research. They don't go through the internal medicine qualifications and boards, and therefore they're not eligible to take the boards in cardiology, and yet they are as competent and fully capable of being appointed to be a department chairman or director of research or whatever.

You don't have to have the boards in cardiology to practice or be a cardiologist.

Q. Now, Dr. Gilmore, you've done a lot of testifying in your day, correct, in different settings?

A. I have testified before, yes.

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Q. But never, never on tobacco issues? This is the very first time in your career, in your life, that you've ever testified in a case, either by way of deposition or by way of personal testimony, in front of a jury on tobacco-related issues; isn't that correct?

A. No. I had a deposition.

Q. In this case.

A. No, you're right. You're right, it was in this case. There was a deposition for this case.

Q. But other than that, other than this case, deposition and today your trial testimony, you have never in your life testified in a case involving tobacco-related issues?

A. That's correct.

Q. Now, as a result -- you've done a lot of testifying in workmen's compensation cases, haven't you?

A. Yes.

Q. What do you figure, you've given 50, 60 depositions in those kinds of cases in your career?

A. Yes, in my career that many.

Q. Okay. Well, what is the issue usually in a workmen's compensation case involving your area of specialty? I mean, my guess would be that a worker would be claiming that he or she suffered a heart

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attack and that it was work connected. Is that the usual issue?

A. Yes.

Q. And in what, 90 percent of the cases you testify for the insurance company against the worker in those workmen comp cases? Your testimony is that the heart attack should not be compensable?

A. That's correct.

Q. Because, apropos your testimony today, how do you ever know what caused the heart attack? How would you know if it's work related? That's generally where you're coming from testifying in workmen's comp cases, correct?

A. Well, in workmen's compensation cases I think that you're in part correct. But in worker's compensation cases usually that the cause is proximate to the attack, that is that the accident or injury occurred near in time to the heart attack or injury. So it's a little bit different than that, this which is a chronic illness over long term in cigarettes.

Q. In workmen's comp cases, you've testified against employees in situations where the employee was doing something strenuous, lifting, hard work, either developed a heart attack on the spot, later that night or the next day and you said you didn't think the work

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caused the heart attack?

A. No, if he was doing an unusual exceptional worker injury, then I usually would testify that that is the cause.

Now, you said I have testified many times, and I agreed. If I am referred a case, and I believe the injury caused a heart attack, it never goes to court or hearing. To my knowledge, then, always the company would settle.

Q. But the cases where you've given the 70 or 80 depositions were cases where you felt that the heart attack was not job related?

A. Yes.

Q. You don't smoke?

A. No.

Q. Never in your life?

A. No. Never in my life.

Q. And you, I assume at a young age, became interested in science and biology?

A. Yes.

Q. And you knew probably as a kid that the idea of lighting tobacco and repeatedly puffing and inhaling into your body 5,000 chemicals could not possibly be good for anybody's health. It could only have a down side. Right?

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A. I didn't know of any benefits to smoking, that's correct.

Q. And you still don't?

A. And I still don't.

Q. Is it fair to say that in all your years of practice, although you've testified you always tell smokers to stop smoking, that you've never told someone: I think you should take up smoking. You never said that to a patient?

A. I never said that.

Q. Even if they were nervous and they thought maybe smoking would calm them down or relieve their stress, you never made that recommendation?

A. That's correct.

Q. You would be shocked if any decent, competent doctor ever made such a recommendation?

A. I would be shocked.

Q. Mr. Ross asked you a lot of questions about risk factor, cause. Have you ever in your career written an article dealing with these subjects where you've discussed risk factor, cause, as it related to heart disease?

A. No.

Q. Now, having had, you know, a lot of experience testifying in workmen's compensation cases,

you know and you've dealt with a lot of lawyers over the years, correct?

A. Yes.

Q. And you've testified, I guess, in medical malpractice cases as well?

A. Yes.

Q. And you know how lawyers work, to a certain extent, that if a lawyer, plaintiff or defendant, is looking for an expert in a particular field, ordinarily what the lawyer does is he'll search the literature. You know, whose written about hypertension, whose written about gastroenterology, I mean, who are some of the superstars in that field, that's one of the things, best in America?

MR. ROSS: Objection. Hypothetical, not based on anything.

THE COURT: Well, this is something that the lawyers may do but the doctor is not aware of, so in that regard I'll sustain the objection.

MR. ROSENBLATT: I'm asking if he is aware of it.

THE COURT: Well, if the question is: Are you aware --

MR. ROSENBLATT: That's the question.

BY MR. ROSENBLATT:

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Q. You're aware of that, aren't you?

A. I don't know the answer to the question.

I think, at least my own experience is that when a lawyer comes to me, he likes to present the problem to me, and then he says: What do you think? And if I tell him that I think that it's a case that he should pursue, then he pursues it.

Q. But why would a lawyer go to you as opposed to a thousand other cardiologists, and you know part of the reason is, for example in workmen's comp the reason a lawyer would go to you, especially an insurance lawyer, is because you have a track record. And obviously you're willing to review files in workmen's comp and give your opinion, correct?

A. Yes, that's true.

Q. Now, if someone was researching a doctor, cardiologist, who was knowledgeable on the subject of what causes heart disease -- does cigarette smoking cause heart disease -- and they searched the literature, they'd never find you, because you haven't written anything in that area, correct?

A. That's correct.

Q. Now, I assume you're aware of the fact that Dr. Susan Oparil testified in this case yesterday, are you aware of that?

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A. Yes.
Q. Do you know her?
A. No.
Q. But you know of her?
A. No.
Q. Never --
A. I know of her from yesterday because I was told she testified yesterday.
Q. Ever read any of her articles?
A. I don't remember the names of authors, but I don't remember ever reading anything by her.
Q. She said she did about like 360 articles that are in the literature in your field. You don't remember reading one?
A. I may have read the article, but I don't remember the authors.
Q. Tell me if you agree with Dr. Oparil's testimony yesterday on this subject.
A. Yes.
Q. She said --
MR. ROSS: Objection, Your Honor.
THE COURT: Overruled.
BY MR. ROSENBLATT:
Q. She said that when you talk about heart disease, generically, 90 percent of heart disease is

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this category (indicating).

THE COURT: Which is?

BY MR. ROSENBLATT:

Q. Which is coronary heart disease, coronary artery disease, do you agree or disagree?

A. Well, if you talk about the United States and say the dollar volume or the number of patients, that's true.

Q. So I mean, in general, although Mr. Ross went down all of these, this represents 10 percent (indicating).

90 percent in America is represented by this (indicating).

A. Well, for example, hypertension -- I agree that the cause of death and disability is coronary artery disease. But, for example, hypertension is -- maybe 40 or 50 percent of the population has hypertension. So it's a common problem, but it's not as expensive as coronary artery disease.

Q. Dr. Gilmore, millions of people -- hypertension is controllable. Hypertension is not a disabling disease. If someone is seeing a doctor, they're taking medication and it's under control, it's not like having a heart attack, right?

A. It's not like having a heart attack, right.

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Q. Okay.

Dr. Oparil said yesterday that smokers have a 60 percent increased risk for developing coronary disease. Do you agree or disagree with that?

A. I agree.

MR. MOSS: Objection, Your Honor.

THE COURT: Why don't you come over here and talk about this for a second.

(The following proceedings were had at sidebar:)

MR. MOSS: Judge, it's improper, number one, that's a mischaracterization of what she said. Even assuming it was fairly close, it's improper --

MR. ROSENBLATT: It's a direct quote.

THE COURT: Wait.

MR. MOSS: It's improper to ask one witness to comment upon the testimony of another witness. I mean, he knows how he can do it. That was the problem with the first one.

THE COURT: The first one slipped by me. I thought about it in retrospect. Then there's the other rule, which always works in conflict, that an expert can always testify about trial testimony.

MR. ROSS: He can testify about facts that are brought up during the trial.

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THE COURT: And one of the facts that this person has talked about is this kind of thing. But you think about these things because it's instantaneous. It comes to your mind. And then in retrospect, that's why I asked you to come sidebar, I agree with you, basically.

If you're going to go down her testimony each and every time, the only way you could really do it without mentioning her is to say: Do you agree with this statement? And then in closing argument is when you do it. That's when you make references to it.

MR. ROSENBLATT: I don't really have a problem. But understand I'm not asking him to comment. I'm saying: Agree, disagree. That's it.

THE COURT: If they disagree, then you're putting the two of them in conflict with each other. The first rule is more correct than the second rule.

If you're going to make any reference to testimony she gave yesterday, just do it generically; then later you can tie it up. So I'll sustain the objection.

MR. MOSS: He shouldn't be able to refer to other testimony in this case.

MR. ROSS: I think you can ask the witness: Is there a 60 percent increase in heart disease?

THE COURT: I understand. That's what I'm saying. You can say: Do you agree with the following statement? Just like you would in taking a treatise for that matter, take something out of the treatise. We're not going to make any reference to prior testimony from witnesses. That's what you're complaining about.

MR. ROSS: My concern is saying: Do you agree with the following statement: If you had a treatise and somebody recognized that that was a treatise, then you could recognize that.

I think the appropriate way to do it is to say: Is there a 60 percent increase in heart disease, or something to that effect.

THE COURT: He can ask the question any way he wants: Do you agree with the statement? No problem. As long as the statement is accurately proven. Okay.

(The sidebar conference was concluded, and the following proceedings were held in open court:)

BY MR. ROSENBLATT:

Q. Dr. Gilmore, do you agree or disagree with the statement that smokers have a 60 percent increased risk for developing coronary artery disease?

A. Yes, I do.

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Q. Do you agree or disagree with the statement that cigarette smoking increases the probability of getting a heart attack?

THE COURT: Can we go back to the first question. The way the question was asked and the answer doesn't make sense. The question I think is: Do you agree or disagree with the statement? And you said: Yes, I do.

THE WITNESS: I'm sorry.

MR. ROSENBLATT: Thank you, Judge. I made an assumption as to how he was answering it. But okay.

BY MR. ROSENBLATT:

Q. I assume you meant you agree with that statement?

A. I agree that the risk is about 60 percent greater.

Q. And do you agree with the statement that smoking increases the probability of getting a heart attack by 60 percent?

A. Yes, I agree with that.

Q. And you would agree that smoking is related to hardening of the arteries, coronary artery disease and peripheral vascular disease, correct?

A. The relationship is an increased risk factor, yes.

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Q. Have you ever done any research in this field?

A. No.

Q. Have you ever done any research, period, where you applied to a funding agency such as NIH or any other funding agency for money to conduct research?

A. Yes.

Q. And what research did you conduct?

A. I don't remember, I think it was on anti-arrhythmics. I had several grants from the American Heart Association, but I honestly don't remember what the subjects were.

Q. It was that long ago, you mean?

A. It was when I worked for the University of Miami.

Q. What year did you stop there?

A. I worked there from 1956 to 1969.

Q. About 30 years ago. I mean, you left about 30 years ago?

A. Yes.

Q. When you were at the University of Miami School of Medicine during that time frame, did you see patients or were you strictly academic, teaching?

A. Well, the responsibilities were the teaching of interns, residents, fellows, and the responsibility

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for patient care. So I had private patients. But more than that I had teaching rounds with the interns, residents and students. And I was involved in a small amount of research.

Q. But you didn't actually have a practice where you saw patients on a regular basis? The only time you dealt with patients were -- I assume these were hospitalized patients and you would make rounds with residents or interns?

A. Yes, that's true. But I had the clinics, I mentioned the hypertension and cardiology clinic and peripheral vascular. But in addition I had a private practice.

Q. Did you ever do an article on -- talk about animal models, mechanisms?

A. No.

Q. How did they get your name? Do you know, how did they hear of you?

MR. HEIM: Objection.

THE COURT: Sustain the objection unless he knows because they told him.

BY MR. ROSENBLATT:

Q. I assume when you were first contacted in this case -- how were you first contacted about being a witness in this case?

A. Well, in 1996 I was contacted by a member of the law firm regarding tobacco cases. And I reviewed tobacco cases when they were sent to me and had conferences sometimes. And then this case came in 1997, I presume as a result of the work in 1996.

Q. What I'm trying to find out, Dr. Gilmore, is the very first time you were contacted by a lawyer about reviewing a case or testifying in a case involving tobacco and health, who was the lawyer who contacted you?

A. I don't remember his name, but it was from Shook Hardy and Baker (sic) in Kansas City.

Q. Had you ever been contacted by them before?

A. No.

Q. They were total strangers to you?

A. Yes.

Q. So a lawyer calls from out of the blue and asks you what?

A. Well, he calls the office and makes an appointment, may I have a conference, I presume. And we had a conference.

Q. He came down from Kansas City?

A. I believe so, yes.

Q. And you don't remember his name?

A. No.

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Q. You would have something in the office, I assume, because you must have billed for that conference?

A. We must have billed, but it might not mention the name of the lawyer, simply the billing office.

Q. Shook, Hardy and Bacon?

A. Yes.

Q. During the course of that conference, did you say to the lawyer: Well, how did you get my name? Or who recommended me? Or how did you hear of me?

A. No.

Q. So to this day you just don't know?

A. I don't know.

Q. Well, do you know any of the local lawyers that are involved in this case?

A. Yes. I know Mr. Ross. But I only know him through this case.

Q. Okay. He's with the law firm of Greenberg and Traurig, did you ever do workmen's comp work or any other kind of testifying for the Greenberg Traurig law firm?

A. I don't remember. I might have.

Q. How about, Coll Davidson is a Miami law firm representing people in this case. Do you know that law firm?

A. No.

Q. How about Ben Reid with the law firm of Carlton Fields? They represent Reynolds in this case and they're a Miami firm.

A. I don't know them. I mean, I may have met them at a conference, but I don't remember or know these lawyers.

Q. How about Ed Moss?

A. No. I didn't know him prior to today.

Q. And you learned today that he's with Shook, Hardy & Bacon?

A. No, I don't believe he's with Shook Hardy & Baker (sic), but I don't know.

Q. He is. But you didn't know that?

A. No.

Q. As you sit here today you have no idea how the law firm of Shook Hardy and Bacon ever heard of you and why they contacted you?

A. That's correct.

Q. You agree, don't you, Dr. Gilmore, that coronary heart disease is the leading cause of death in the United States?

A. Yes, I do.

Q. Have you ever read a Surgeon General's report?

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A. Yes. They're very long, so I may not have read the whole thing, but I've looked at the surgeon general's reports, yes.

Q. Did you read the 1983 Surgeon General's Report, which I believe dealt with cardiovascular disease?

A. Yes.

Q. So you're aware that the 1983 Surgeon General Report concluded that cigarette smoking is a major cause of coronary heart disease in the United States for both men and women?

A. Yes.

Q. You just disagree with that? They should have said "risk factor"?

A. When you read the report he uses the word "risk" as well as "cause." And he's had -- that is, it's not a "he," it's an office of the Surgeon General. And they have a report on nutrition and diet which uses the same kind of language, and they have a report on physical activity, which uses the same kind of language, saying that these are causation, or if you took away the risk, the disease would be less.

Q. You're not saying there's a Surgeon General's Report on nutrition and diet; I think what you're saying is that, included within the 1983 Surgeon

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General's Report on cigarette smoking and its relation to coronary heart disease, they discussed some of these other things. That's what you're saying?

A. No, I'm saying there's a separate Surgeon General's Report on diet and nutrition saying that this is a risk factor or cause of coronary artery disease.

Q. What year is that, the Surgeon General's Report on diet and nutrition?

A. Well, I can't tell you for sure. It might be 1998 -- or 1988 and there's a report -- there are many Surgeon General reports, and they're successive years. And as I say, they don't offer a balanced view of the debate about risk factors and causation. And they do conclude, as you say, that smoking is a cause of coronary artery disease or arteriosclerosis.

Q. What have some of the other Surgeon General's Reports, what have been some of the general titles of some other Surgeon General's Reports? Obviously there have been some on smoking, you mentioned one on diet and nutrition. What other subjects?

A. There's one on physical activity.

Q. A Surgeon General's Report on physical activity?

A. Yes.

Q. What year do you think that is?

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A. It's in the 1990s.

Q. Okay. Any other general subject matters?

A. No. Relative to my specialty of cardiology these are risk factors and so I'm aware. And as I say, I've read or glanced through the Surgeon General Reports. And the gist of his message is that these are modifiable risk factors that should be addressed.

Q. The Surgeon General devoted complete reports to diet and nutrition and another complete report to physical activity?

A. Yes.

Q. Now, I've heard, obviously, and the jury has as well, because we've had a lot of board certified physicians testify on behalf of the plaintiffs, we understand the concept of internship, residency, fellowship, but this is a new one on me: Trainee. You said you were a trainee in the field of cardiology. What does that mean?

A. It's the same as a fellowship. They were addressed as fellowships or trainees.

Q. When you completed your study as a trainee, did you get a certificate --

A. Yes, I did.

Q. -- of some kind?

A. Yes, I did.

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Q. Do you have it, which would indicate, as you would, of course, when you complete an internship or residency or fellowship, are you saying that you've got a certificate indicating that you completed a period of study as a trainee and received some kind of title as a result thereof?

A. I may not have it, but I did receive a certificate that said I completed a traineeship or fellowship in cardiology. And I received two of them, one from Philadelphia General Hospital and one from the University of Miami.

Q. Now, internal medicine basically covers the entire body, the only thing it doesn't involve is surgery, correct?

A. That's correct.

Q. So that someone who specializes in the field of internal medicine might be a gasteroenterologist or could focus in on the heart or could focus in on other areas of the body, correct?

A. Yes.

Q. As a matter of fact you, early in your career you got a fellowship I believe in the field of gasteroenterology?

A. Yes.

Q. Which is what, essentially the stomach?

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A. That's the stomach and bowel, the small and large intestines.

Q. Totally unrelated to cardiology?

A. Yes.

Q. Now, I'm looking, Dr. Gilmore, at your curriculum vitae where you list certain articles.

Have you ever published an article for example in the New England Journal of Medicine?

A. No.

Q. Have you ever had an article of yours published in the Journal of the American Medical Association?

A. No.

Q. And I see in looking over your list of publications, one was in 1957, you've got seven or eight in the 1960s. And then you have in the early '70s, 1971 and 1972. Have you published any articles in any medical journal after 1972?

A. No.

Q. Without going through the publications from the 1960s and early '70s, ending in 1972, is it fair to say that none of your publications dealt with the issue of tobacco and health and none of your publications dealt with the subject of causation?

A. That's correct.

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Q. Is it fair to say, Dr. Gilmore, when the lawyer whose name you forget from Shook Hardy and Bacon came down from Kansas City and had the meeting with you, that what he wanted you to do was to review the file of an individual as opposed to, you know, generically discuss causation as opposed to risk factors? He wanted you to look at a file of an individual who had heart disease, correct?

A. That's correct.

Q. And you say that first contact was in January of '96?

A. I don't remember the month, but it was in 1996.

Q. You do not -- since you left the University of Miami when you were full-time there, you left in 1969, I understood you to say that you've maintained a relationship with the School of Medicine, but you've not actually taught there on a regular basis. I think you said in your testimony about once a month?

A. Yes.

Q. And a lot of doctors who practice in the community -- sometimes it's the same with law school -- sometimes in terms of adjunct professor or something like that.

You would agree that a lot of practicing

doctors in the community have that kind of relationship with a medical school.

A. That's true.

Q. Is it fair to say, Dr. Gilmore, in terms of your own practice, about 40 or 50 percent of the patients that you see with heart disease are smokers at the time you see them the first time?

A. I don't have an accurate figure. But that may be true.

Q. Well, I think when your deposition was taken, that was your best estimate?

A. I think that's my estimate, yes.

Q. Okay. And you tell all of them to stop smoking?

A. Yes.

Q. And you've had many patients who were smokers and who had serious heart disease who you told in pretty emphatic terms to stop smoking and a certain percentage of them, for whatever reason, did not stop or could not stop, correct?

A. That's right.

Q. And that's very upsetting to you as a physician?

A. That's correct, yes.

Q. Because, you know, one of the distinctions

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between modifiable risk factors and nonmodifiable risk factors, obviously if someone is a higher risk because they're a man rather than a woman, they can't change that, although there's some operations around the country. But I mean, basically you're stuck, you're either a man or you're a woman. You can't change your family history. Your parents have whatever diseases they had and whatever family history you had, you're stuck with.

But cigarette smoking is something that the individual has some control over, wouldn't you think?

A. Yes.

Q. And to those patients who are unable to quit smoking, you've sent them to clinics, you've had them use the patch, you've had them use gum, nasal spray, Zyban, the whole spectrum?

A. I don't think I've ever had anybody use the nasal spray, but everything else, yes.

Q. Zyban is something kind of new, isn't it?

A. Yes, it is.

Q. And you've been fairly impressed with that, haven't you?

A. Yes, I don't have a large experience with it but it seems to be more effective than any of the other programs.

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Q. And to a certain extent, Zyban, and you've seen that advertised on television I'm sure --

A. Yes, I have.

Q. -- on national programs?

A. Yes, I have.

Q. Just as you've seen Nicorette gum advertised on national programs?

A. Yes, sir.

Q. I think they're advertising a mint flavor now. Have you seen those?

A. I haven't seen them.

Q. Obviously there's a lot of people out there who need help, a lot of smokers that need help, because that's expensive advertising, isn't it?

MR. HEIM: Objection, beyond the scope.

THE COURT: I agree, sustained.

BY MR. ROSENBLATT:

Q. And you've had patients with serious heart disease who were smokers tell you, in effect: Doctor, I know you mean well, but get off my back, I'm going to keep smoking?

A. Yes, I have.

Q. You know, as I listened to your testimony, and tell me if I've got it right, to me your bottom line is, because of all these risk factors, you can

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never know, you, Dr. Gilmore, cardiologist, can never know in an individual case what caused this person's coronary heart disease?

A. That's correct.

Q. Isn't that frustrating when people say, patients say to you, you know, why? And your answer is you don't know?

A. That's exactly right.

Q. And even if someone was a two-pack-a-day smoker for 30 years, they exercised, they weren't overweight, they had a good family history, there were really no other really strong risk factors, even in that case you wouldn't say that the two packs a day for 30 years caused the heart attack. It would still be: I just don't know?

A. I would say to the patient: I don't know what caused your heart attack, but you're at very high risk smoking so much cigarettes. And I'm asking you to stop.

Q. Isn't it really semantics, the difference between -- you know, Mr. Ross said: It's not really semantics. You can call it a risk factor. But in terms of your everyday practice with real, live people and patients that you care about, and that you have a responsibility toward, and who come to see you seeking

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your best advice, if they smoke, you tell all of them: Stop smoking.

So what's the difference if you call it a risk factor or cause? It's just semantics, isn't it?

A. Well, the bottom line is I tell them to stop smoking.

Q. Right, so it really doesn't matter whether it's risk factor, it certainly doesn't matter to them because what you're telling them is: Stop. Correct?

A. I tell them to stop. That doesn't mean that they're never going to get heart attacks or progression of the disease or whatever, but I do tell them to stop.

Q. Let's talk a little bit about this concept of cause.

You remember the disaster that happened in this country with a drug called Thalidomide.

A. Yes, I do.

Q. Pregnant women took that drug. It was an anti-nausea medication. And it caused some babies to be born missing arms, correct?

A. That's my memory, correct.

Q. But, you know there were some women who took Thalidomide and gave birth to perfectly normal babies, didn't happen 100 percent?

MR. ROSS: Objection, Your Honor, completely

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beyond the scope of direct.

THE COURT: I think he's using an example. Overrule the objection. See where it goes.

BY MR. ROSENBLATT:

Q. The point I'm making, what I'm asking you about, you recognize that some pregnant women who took the drug Thalidomide had perfectly normal babies?

A. That's true.

Q. Okay. But that fact in no way changes the fact that in those babies who were born without arms, the cause of that was their mother having taken Thalidomide?

A. I believe that's true.

Q. Just as with AIDS, not everyone who has sex with someone who is either HIV positive or who has AIDS, not 100 percent of the people that have sex with that person are going to get AIDS. Some people have protection?

MR. ROSS: Objection, Your Honor.

THE COURT: Overrule. I think it's being used for examples for the purpose of determining the causation effect. I think is appropriate.

BY MR. ROSENBLATT:

Q. Isn't that true?

A. Well, the Thalidomide example is easy. But

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the AIDS example is so complicated. It has to do with dose or resistance or immunity, so it's not as good of an example in terms of Thalidomide in terms of cause and effect.

Q. For your time that you've got in this case you charged, what, $300 an hour?

A. $300 an hour for depositions and conferences. And it's $200 for reading case reports in general. So it's between $200 and $300 an hour.

Q. You figure you've got about 100 hours in the case or more?

A. In this case?

Q. All the tobacco --

A. Since 1996?

Q. Since you were first hired by that lawyer from Shook, Hardy & Bacon.

A. I would bet it's 100 hours at least, yes.

Q. At least. It could be more?

A. Could be more.

Q. Okay. So if it's $300 an hour for 100 hours that's $30,000 you've made from the tobacco companies?

A. Since 1996, yes.

Q. And they pay as soon as you bill, don't they?

MR. MOSS: Objection, Your Honor.

BY MR. ROSENBLATT:

Q. They pay good?

MR. MOSS: Objection.

MR. HEIM: Unlike plaintiffs' counsel.

MR. ROSENBLATT: Absolutely. Unlike plaintiffs' counsel, which is coming out of my pocket.

MR. MOSS: Well, Your Honor --

THE COURT: All right. Gentlemen, enough.

BY MR. ROSENBLATT:

Q. Now, you don't think you've ever gone to court representing the person who was injured or representing the person, the family of the person who died; you were always on the defense side?

A. I'm not always on the defense side. But in terms of appearing in court it's always been on the defense side.

Q. Now, we were provided with a list of attorneys that you have reviewed files for in workmen's compensation cases.

Did you ever ask any of those attorneys, who you know personally in the Miami area, whether they recommended you to testify in this case.

A. No, I did not.

MR. ROSENBLATT: Judge, in terms of -- it's going to be a short day. I mean, if we go --

MR. MOSS: Why don't we go sidebar?

MR. ROSENBLATT: That's fine.

(The following proceedings were had at sidebar:)

THE COURT: What are you trying to tell me?

MR. ROSENBLATT: This is what I'm trying to tell you. I started thinking to myself: Well, let me ask for a lunch break. But then I'm thinking, we could take a lunch break, then we come back, I might be a half hour.

But here's my problem. I would have to call Susan to discuss, tell her where I'm at -- she's at the office -- if you decide you'd want to finish before lunch. I'd need a little break and I might finish in a half hour.

THE COURT: That's fine. We'll go ahead and finish up with your cross. Are you going to have much redirect?

MR. ROSS: Five, ten minutes so far.

THE COURT: If we finish with this witness by 1:00, what have you got for the rest of the afternoon? We could {} put Moss on, Moss on, and see what he has to say.

MR. MOSS: I'd be glad to.

MR. HEIM: I mean, I can do it one of two ways. I could probably get Dr. Karshman here and get

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him started.

THE COURT: Let's try that see what we've got. No sense wasting the afternoon.

MR. ROSENBLATT: What other witness? I mean the only names you gave me was Carchman to finish out this week. If we were to put Carchman on today --

THE COURT: I'm sure they're not going to be too unhappy if Friday is a short day.

MR. ROSENBLATT: Or off.

THE COURT: It's only Tuesday. Let's finish up with this witness.

MR. ROSENBLATT: Well, in view of the fact that you're saying -- it's the only good suggestion that I agree with.

Now what I'm thinking, since we're coming back anyway, I wouldn't mind taking a break now representing to you even after I talk to Susan, I'm going to be a half hour, an hour tops.

THE COURT: Then in that event, if you have somebody this afternoon --

MR. HEIM: I could get them started.

THE COURT: Do the C.V.s and that sort of thing.

MR. HEIM: I guess what Stan and I are both saying, we start him this afternoon, we're probably

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going to finish by the end of the day Thursday, I would think, with him, that's my guess, if that. So let's see where it goes.

MR. ROSENBLATT: You can't get another witness for -- I'm not pushing. I'm not pushing, unless the judge is.

THE COURT: Well, they told me six to eight weeks, basically, on their case, essentially. We've got four weeks left before the end of April. Considering the problem --

MR. ROSENBLATT: April is a weird month.

MR. HEIM: I think we're roughly on target. I mean, even taking into consideration --

THE COURT: You don't have to take all this down.

(Discussion off the record.)

(The sidebar conference was concluded, and the following proceedings were held in open court:)

THE COURT: Folks, we've been talking about the scheduling situation, lunch. We decided to go ahead and take our lunch break now, finish up with this witness after lunch. So go ahead and come back -- it's now a little after 12:00. Why don't you come back at 1:15. That will give you an hour and ten minutes or so.

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(The jurors exited the courtroom.)

THE COURT: All right. We'll be in recess until 1:15.

(A lunch recess was taken at 12:10 p.m.)